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LATHAM & WATKINS LLP

December 14, 2018

VIA ECFS

Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

Re: ***In the Matter of Promoting Connected Care for Low-Income Consumers*, WC Docket No. 18-213**

Dear Ms. Dortch:

On December 12, 2018, Karen Rheuban of the Virginia Telehealth Network, Matthew Brill of Latham & Watkins LLP, and the undersigned spoke with Jodie Griffin, Deputy Division Chief of the Telecommunications Access Policy Division, and with Rashann Duvall, Attorney Advisor for the Telecommunications Access Policy Division, regarding the above-referenced proceeding. We expressed how empirical studies have shown that connected care programs lead to improved health outcomes. We explained that—to ensure that this funding has the greatest impact—it should be used to subsidize broadband connectivity for patients via a fixed discount, and to provide patients with remote monitoring hardware that can launch connected care software. We cautioned against imposing a requirement that broadband providers participating in these pilot programs be eligible telecommunications carriers because such a requirement would discourage providers from providing connectivity to patients through this initiative. And we advised the Commission only to award pilot program funding to medical facilities that take charge of Medicaid-eligible patients' general primary or specialty medical care needs. Lastly, we encouraged the Commission to establish an interagency connected care working group to identify roadblocks to the adoption of connected care practices. In support of our views, we presented the attached slide deck at the meeting. We also agreed to provide the Commission additional information about how the Centers for Medicare and Medicaid Services has released new reimbursement codes for connected care hardware and services.

Pursuant to Section 1.1206(b) of the Commission's rules, 47 C.F.R. § 1.1206(b), this *ex parte* notification is being filed for inclusion in the public record of the above-referenced proceeding.

LATHAM & WATKINS LLP

Please contact the undersigned with any questions regarding these issues.

Respectfully submitted,

/s/ Jason M. Gerson

Jason M. Gerson
of LATHAM & WATKINS LLP
Counsel for the Virginia Telehealth Network

cc: Matt Brill
Karen Rheuban

Enc: Connected Care Pilot Programs Recommendations Presentation
Connected Health Presentation: Summary & Rapid Reax: Final CY 2019 PFS / QPP & HPPS

CONNECTED CARE PILOT PROGRAM RECOMMENDATIONS

Karen Rheuban, MD

Chair of the Board of Trustees

December 12, 2018

OVERVIEW

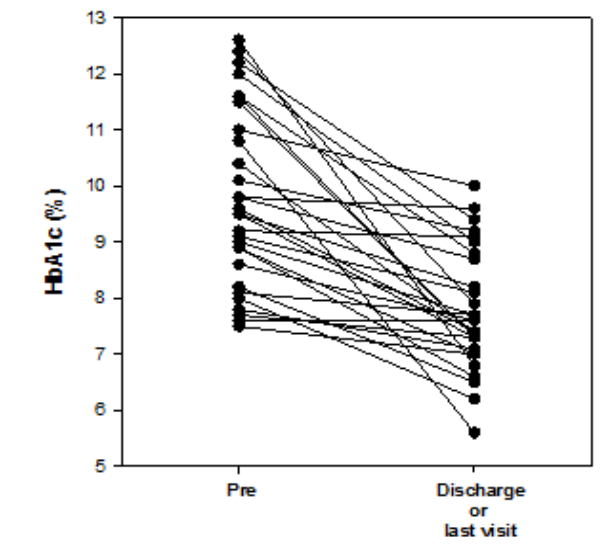
- Who We Are
- Why Patients Need Connected Care
- Allocating the Funding for Hardware and Connectivity
- Setting Eligibility for Funding
- Ensuring the Connected Care Pilot Program Is Not Duplicative
- Legal Authority to Establish This Pilot Program
- Conclusion

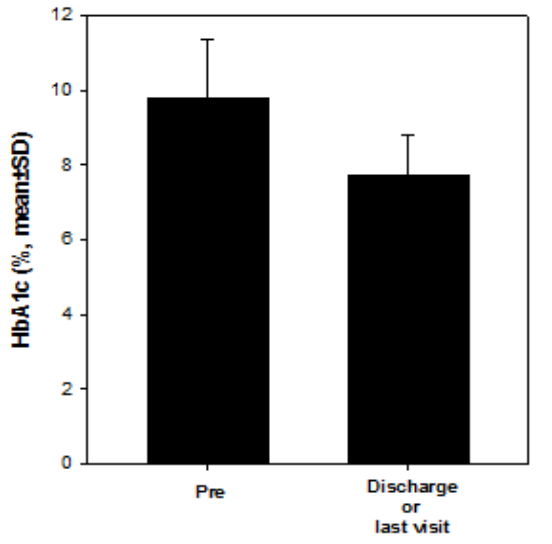
WHO WE ARE

- We are a nonprofit organization dedicated to advancing the adoption, implementation, and integration of connected care and related technologies throughout Virginia.
- VTN members include academic medical centers, community hospitals, federally qualified health centers, individual practitioners, telecommunications providers, payers, the Medical Society of Virginia, and other entities.
- We hold conferences and help to facilitate advancements in connected care initiatives across Virginia.
- Dr. Rheuban also participates in the American Medical Association's Digital Medicine Payment Advisory Group.

WHY PATIENTS NEED CONNECTED CARE

The use of connected care technologies helped diabetic patients significantly reduce their Hemoglobin A1c levels—from a mean of 9.9% (suggesting uncontrolled diabetes) to 7.7% (considered diabetic control by this study).





ALLOCATING THE FUNDING FOR HARDWARE AND CONNECTIVITY

- The Commission proposed allocating its $100 million in connected care funding across 20 pilot programs, but spreading this funding across 20 different pilot programs may well hamper how much impact any one program can have. We instead suggest that the Commission limit participation to 10 programs, with each receiving up to $10 million.
- The pilot program funding should be set aside for only two purposes:
  - (i) to subsidize broadband connectivity for patients via a fixed discount; and
  - (ii) to provide patients with remote monitoring hardware loaded with appropriate connected care apps and software.
- The Commission should not impose an ETC requirement on participating broadband providers. Instituting such an ETC requirement would limit how many ISPs can participate in the pilot program. If the Commission later wishes to impose an ETC requirement, allowing non-ETCs to participate in the pilot phase may incentivize them to become ETCs once the Commission decides to authorize permanent funding for this program.

SETTING ELIGIBILITY FOR FUNDING

- The Commission should award pilot program funding only to entities that include primary and secondary medical homes that provide care to Medicaid beneficiaries.
- Primary medical homes provide coordinated care for a patient's overall health, and specialty medical homes coordinate treatment for a specific medical condition of a patient—such as treating a neurological condition.
- Entities should demonstrate engagement with and support from their state Medicaid agency.

SETTING ELIGIBILITY FOR FUNDING, CONTINUED

- The Commission should not grant funding to entities that exclusively provide connected care services without integration into the patient's medical home.
- To ensure that urban and rural communities alike benefit from the funding being awarded, the Commission should require that participants in the pilot program commit to serving a minimum percentage of covered patients (e.g., 50 percent) in rural communities.
- For these pilot programs, funding should be awarded to entities with a clear track record of integrating remote monitoring and telehealth services—including entities federally designated as Telehealth Resource Centers or as Telehealth Centers of Excellence, as well as the Veterans Health Administration. Providing funding to these trusted providers will help the Commission avoid delays in launching the program.

ENSURING THE CONNECTED CARE PILOT PROGRAM IS NOT DUPLICATIVE

- The VA's Home Telehealth Program is the only federal effort to help healthcare providers provide connected care hardware and connectivity. We do not foresee the Connected Care Pilot Program being duplicative of other existing efforts within the government.
- However, the Commission should establish a connected care interagency working group to identify roadblocks to the adoption of connected care practices.
- The Commission should also work with CMS to learn about how to best allocate this funding across regions and across types of healthcare providers.

LEGAL AUTHORITY TO ESTABLISH THIS PILOT PROGRAM

- Section 254 authorizes the Commission to "designate . . . support mechanisms for . . . health care providers" if doing so would "enhance . . . access to advanced telecommunications and information services" for those health care providers.
- The Commission has already relied on Section 254(h)(2)(A) to establish a funding mechanism "to enhance public and non-profit health care providers' access" to broadband services. *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111, para. 1 (2006) (2006 Pilot Program Order).
- That same authority supports adoption of the Connected Care Pilot Program.

CONCLUSION

- This Pilot Program has the potential to transform how low-income patients benefit from connected care.
- The Commission should focus this initial funding to ensure low-income Medicaid beneficiaries receive care integrated into primary or secondary medical homes.
- We welcome your outreach and any additional questions as this rulemaking proceeding continues.

Summary & Rapid Reax: Final CY2019 PFS/QPP & HHPPS

Connected Health Initiative

Brian Scarpelli

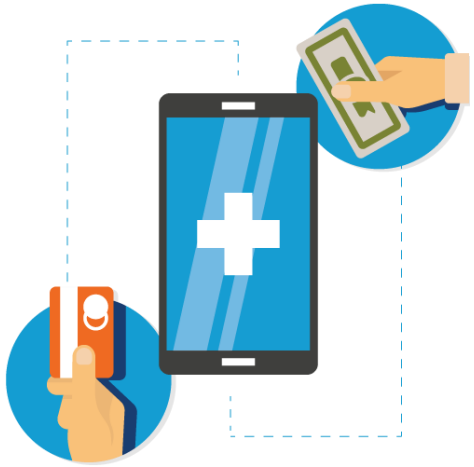
Agenda

- About CHI
- Physician Fee Schedule (PFS)
- Quality Payment Program (QPP)
- Home Health Prospective Payment System (HHPPS)
- Discussion/Questions

About CHI

- ACT | The App Association is a 501(c)(6) association effort to advance uptake of digital health tools widely
- Intersection of medical/health industry and technology innovators
- Advocate before Capitol Hill, US agencies, European Commission, etc.
- Active in key private-sector initiatives (AMA Digital Medicine Payment Advisory Group, Xcertia, etc).

About CHI



ConnectedHealth

Medicare Reimbursement – Background and Status Quo

- "Telehealth" vs. "Store-and-forward"
- 1834(m) & the historical treatment of "telehealth"
  - Telehealth Services List
- "Historical" treatment of remote monitoring
  - Remote monitoring is not telehealth subject to 1834(m) restrictions
  - 99091 (CCM)
- New bills:
  - Bipartisan Budget Act (Medicare Telestroke, ESRD, MA, ACOs)
  - SUPPORT for Patient and Communities Act

CY2019 PFS & Digital Health

- HCPCS code G2012 – Brief communication technology-based service (e.g. virtual check-in).
- HCPCS code G2010 – Remote evaluation of pre-recorded patient information.
- CPT codes 99446, 99447, 99449, 99451, 99452 – Interprofessional internet consultation.
- CPT codes 99453, 99454, and 99457 – Chronic care remote physiologic monitoring.

CY2019 PFS: HCPCS G2012

- "Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion."

CY2019 PFS: HCPCS G2012

- Performed by a physician or other qualified health care professional who can report E/M services
  - Must be established patient
  - Allows:
    - Audio-only real-time telephone interactions
    - Two-way audio interactions enhanced with video or other kinds of data transmission
  - Not originating from a related E/M service provided within previous 7 days
  - Not leading to an E/M service or procedure within the next 24 hours or soonest available appointment
  - 5-10 minutes of medical discussion
  - No frequency limitations
- Work RVU of 0.25, based on a direct crosswalk to CPT code 99441

CY2019 PFS: HCPCS G2010

- "Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment"

CY2019 PFS: HCPCS G2010

- Remote evaluation of pre-recorded patient information
  - Information = recorded video and/or images submitted by patient
    - Used to determine if a visit or service is needed
  - Must be established patient
  - Not originating from a related E/M service provided within previous 7 days
  - Not leading to an E/M service or procedure within the next 24 hours or soonest available appointment
  - Includes interpretation with follow-up within 24 business hours
    - Via phone call, audio/video communication, secure text message, email, or patient portal communication
- Valuation as proposed with an WRVU of 0.18

CY2019 PFS: CPT 99453, 99454, and 99457

- Remote monitoring of physiologic parameter(s)(e.g. Weight, blood pressure, pulse oximetry, respiratory flow rate)
  - CPT 99453 – Initial; set-up and patient education on use of equipment
  - CPT 99454 - initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
  - CPT 99457 - treatment management services (WRVU of 0.61)
    - 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month
- CMS will provide additional guidance regarding what types of technology are covered under these codes

CY2019 PFS: CPT 99453, 99454, and 99457

NOTE: Payment $ below are based on projected Conversion Factor close to final CY2019 Conversion Factor ($36.0463) – we will update with exact payment $ ASAP

Payment Code	Description	Payment $	Effective Date
99091	Collection, interpretation of physiologic data, 30 minutes or more per month by physician or other qualified healthcare professional (QHP) (professional component)	$59	2018
990X0 (now 99453)	Initial set-up of technology and patient education (technical component)	$21	2019
990X1 (now 99454)	Device supply with daily recordings, programmed alerts transmission, monthly (technical component)	$69	2019
994X9 (now 99457)	Collection, interpretation of physiologic data, 20 minutes or more per month requiring interactive communication with patient by physician, QHPs, and other clinical staff (professional component)	$54	2019

CY2019 PFS: CPT 99446, 99447, 99449, 99451, 99452

- Interprofessional internet consultation (telephone/internet assessment and management service)
  - CPT 99446 - 5-10 minutes of medical consultative discussion and review (WRVU 0.35)
  - CPT 99447 - 11-20 minutes of medical consultative discussion and review (WRVU 0.70)
  - CPT 99448 - 21-30 minutes of medical consultative discussion and review (WRVU 1.05)
  - CPT 99449 - 31 minutes or more of medical consultative discussion and review (WRVU 1.40)
- Interprofessional internet consultation (telephone/internet/electronic health record)
  - CPT 99451 - Assessment and management service provided by a consultative physician (WRVU 0.70)
    - 5 or more minutes of medical consultative time
  - CPT 99452 - Referral service(s) provided by a treating/requesting physician or qualified health care professional (WRVU 0.70)
    - 30 minutes
- Includes a verbal and written report to the patient's treating/requesting physician or other qualified health care professional
- Billing limited to practitioners that can independently bill Medicare for E/M services

CY2019 PFS: Medicare Telehealth Services List

- Medicare Telehealth Services list:
  - Diagnosis, treatment, or evaluation of acute strokes
  - Treatment of substance abuse or co-occurring mental health disorders
  - Clinical assessment for monthly end state renal disease (ESRD)

CY2019 PFS: Acute Stroke Treatment

- Removes originating site restrictions
  - Services may be furnished in any hospital, critical access hospital, or mobile stroke unit, or any other site determined appropriate by HHS
  - Mobile stroke unit provides services to diagnose, evaluate, and/or treat acute stroke symptoms

CY2019 PFS: Substance Abuse Treatment

- Removes geographic requirements for telehealth services furnished on or after 7/1/2019
  - Individual's home now a permissible originating site
    - No originating site fee required in this case
- Practitioner responsible for diagnosis and determining whether telehealth treatment is clinically appropriate
- CMS will provide additional subregulatory guidance

CY2019 PFS: ESRD

- Removes geographic requirements
  - Individual's home now a permissible originating site
- ESRD patients receiving home dialysis may choose to receive monthly telehealth clinical assessments on or after 1/1/2019
  - Must receive a non-telehealth face-to-face visit on a monthly basis during first three months of home dialysis and at least once every 3 consecutive months thereafter

Quality Payment Program

- ***Activity ID, Title:*** IA_BE_14, Engage Patients and Families to Guide Improvement in the System of Care
- ***Subcategory:*** Beneficiary Engagement
- ***Weighting:*** High
- ***Eligibility for Advancing Care Information Bonus:*** Yes
- ***Full Activity Description:*** Engage patients and families to guide improvement in the system of care by leveraging digital tools for ongoing guidance and assessments outside the encounter, including the collection and use of patient data for return-to-work and patient quality of life improvement. Platforms and devices that collect [PGHD] must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient, including patient reported outcomes (PROs). Examples include patient engagement and outcomes tracking platforms, cellular or web-enabled bi-directional systems, and other devices that transmit clinically valid objective and subjective data back to care teams. Because many consumer-grade devices capture PGHD (for example, wellness devices), platforms or devices eligible for this improvement activity must be, at a minimum, endorsed and offered clinically by care teams to patients to automatically send ongoing guidance (one way). Platforms and devices that additionally collect PGHD must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient (e.g. automated patient-facing instructions based on glucometer readings). Therefore, unlike passive platforms or devices that may collect but do not transmit PGHD in real or near-real time to clinical care teams, active devices and platforms can inform the patient or the clinical care team in a timely manner of important parameters regarding a patient's status, adherence, comprehension, and indicators of clinical concern.

Quality Payment Program

- Clinical Practice Improvement Activities (CPIA) Performance Category
  - "Engage Patients and Families *(using PGHD)* to Guide Improvement in the System of Care" is classified as a "high-weighted" activity
  - "Use of CEHRT to Capture Patient Reported Outcomes" remains a "medium-weighted" activity
- Advancing Care Information (ACI) Performance Category
  - 10% Bonus for using CEHRT to complete at least one CPIA

Quality Payment Program

"For previously finalized improvement activities, we refer readers to the finalized Improvement Activities Inventory in Table F in the Appendix of the CY 2018 Quality Payment Program final rule (82 FR 54175) and in Table H in the Appendix of the CY 2017 Quality Payment Program final rule (81 FR 77818). Unless modified or removed in the CY 2019 Physician Fee Schedule final rule, previously finalized improvement activities continue to apply for the MIPS CY 2019 performance period and future years."

Quality Payment Program

- Remaining challenge: rule text on Alternative Payment Models (APMs) still omits discussion of telehealth/remote monitoring

Home Health Prospective Payment System & RPM

- HHPPS rule CMS is amending 42 CFR 409.46 (HHA allowable administrative costs) to include the costs of remote patient monitoring as an allowable HHA administrative cost (operating expense) if remote patient monitoring is used by the HHA to augment the care planning process.
- In response to calls to align its "remote patient monitoring" definition with new CPT codes:
  - "We recognize that the descriptors for [990X0 and 990X1] allow[] for greater specificity of the process of remote patient monitoring, which in turn would lead to more accurate analysis of the associated costs. While the proposed home health regulations text at § 409.46(e) would permit the cost and service of the equipment to be allowable administrative costs, we agree that set-up and patient education should be allowable expenses reported on the cost report. However, we wish to clarify that a visit to set up and/or train the patient on the equipment would not be allowed on the HHA claim when no other skilled service is provided. In other words, a visit cannot be reported when the sole reason is to set up and/or train the patient on the use of the remote monitoring equipment. Therefore, we are adding language to the regulations text to ensure a more complete description of remote patient monitoring services, with the qualification that such set-up and patient education services cannot be reported as a visit without the provision of another skilled service."

Home Health Prospective Payment System & RPM

§409.46 Allowable administrative costs.

(e) Remote patient monitoring. Remote patient monitoring is defined as the collection of physiologic data (for example, ECG, blood pressure, or glucose monitoring) digitally stored and transmitted by the patient or caregiver or both to the home health agency. **If remote patient monitoring is used by the home health agency to augment the care planning process, the costs of the equipment, set-up, and service related to this system are allowable only as administrative costs.** Visits to a beneficiary's home for the sole purpose of supplying, connecting, or training the patient on the remote patient monitoring equipment, without the provision of a skilled service are not separately bill.

2020 and beyond

Questions/Comments?

Contact

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Connected Health Initiative